AUTHORIZATION TO DISCLOSE INFORMATION

NORTH DAKOTA VETERAN'S HOME
Form # 16 (Rev.12/20/2011)

INSTRUCTIONS: Provide Information as it existed when the service was provided.

Name:	Medical Record Number:	Date of Birth:	
Street Address:	City:	State:	Zip Code

CLIENT RELEASE AND SIGNATURE

1. **I Hereby Authorize:**

Name of Person/Facility:
VA Medical Center

Street Address:	City:	State:	Zip Code:
2101 Elm Street	**Fargo**	**ND**	**58102**

2. **To Release Information To:**

Name of Person/Facility To Receive Information:
ND Veterans Home

Street Address:	City:	State:	Zip Code:
1600 Veterans Drive	**Lisbon**	**ND**	**58054**

3. The Following Information is Requested: (Be specific – include dates where appropriate)

X Nurses Notes X Activity Notes X Physician Orders
X Dietary Notes X Immunization Record X Physician's Progress Notes
X Care Plans X Discharge Summary X Medication List
X Mental Health Records X All Drug/Alcohol Related Information
X History and Physical
X Laboratory Results from
X Consultation Reports from (doctor's names) _____
__ Other _____
X Entire Record

4. The Information Identified Above Will Be Used For: (List Each Purpose)
Admission and On-Going Care

5. This Authorization to Disclose Information Remains in Effect Until: (Date) **three months following admission**

OR: (Specific Event Terminating Operation of the Release) **resident revokes consent**

RESIDENT CONSENT:

This authorization is voluntary and remains in effect until the above date or event, unless specifically revoked by written notice to the facility by the resident. Refer to the Notice of Privacy Practices for further description of revocation rights. Any information disclosed prior to written revocation of this authorization shall not be a breach of confidentiality. A photocopy of this authorization is as effective as the original. Unless otherwise agreed in writing, information may be disclosed under authorization in any form or medium, including oral, written, or electronic transmission.

Signature of Resident or Legal Representative	Date:
If Signed By Legal Representative, Relationship to Resident:	Date:
Signature of Witness (if needed):	Date:

___ CHECK IF APPLICABLE – NOTICE TO WHOMEVER DISCLOSURE IS MADE CONCERNING ADDICTION RECORDS: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the disclosure of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

NOTICE: Except for information subject to 42 CFR Part 2, information disclosed to another entity may potentially be redisclosed, in which case it may not be protected by state or federal law.

DISTRIBUTION: _____ Resident _____ Resident Refused Copy _____ Addiction Chart if Applicable
_____ Requesting Person/Facility _____ Other